DEPAR CENTE	TMENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES		POC#2	FORM	01/17/2012 APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		445494	B. WING_		04/4	4/2045
NAME OF	PROVIDER OR SUPPLIER		ЗТ	REET ADDRESS, CITY, STATE, ZIP CODE		1/2012
LIFE CA	RE CENTER OF RHE	2		7824 RHEA COUNTY HWY DAYTON, TN 37321		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT		F 000			
3	were completed at I January 9- 11, 2012 related to complaint 27539, 28215, 2823 482.13, Regulations	cation survey and Complaint 098, 27539, 28215, 28232 Life Care of Rhea County on 2. No deficiencies were cited t investigation #'s 27098, 82, under 42 CFR PART to for Long Term Care.				10 D
F 164 SS=D	483.10(e), 483.75(l)	(4) PERSONAL ENTIALITY OF RECORDS	F 164	F164		
	Personal privacy incomedical treatment, we communications, personal privacy incomedical treatment, we communications, personal and treatment in the resident release of personal and individual outside the communication in the resident's right to records.	n paragraph (e)(3) of this may approve or refuse the and clinical records to any e facility.		What corrective action will be to correct this alleged deficient properties as the correct this alleged deficient properties and the correct this alleged deficient properties and dignity. b) All personnel were in-serving privacy for residents by the Development Coordinator of 1/9/2012 and 1/26/2012. Identify residents that have the properties to be affected by the alleged definancies. a) All facility residents have the potential to be affected. b) Staff Development Coordinator completed a 100% observation.	actice? of nursing on privacy ced on Staff on potential icient ac	2/24/2012
	resident is transferre institution; or record The facility must kee contained in the resid the form or storage in release is required by healthcare institution contract; or the residual resid	does not apply when the d to another health care release is required by law. p confidential all information dent's records, regardless of nethods, except when y transfer to another	TURE	1/26/2012 of privacy and digall residents. No other residaffected.	gnity of ents were	
	Lato Si	THE REPRESENTATIVE'S SIGNA	TURE	TITLE GD 1	« -27-12	6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 grogram participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: D62011

Facility ID: TN7202

If continuation sheet Page 1 of 16

DEPAR	RTMENT OF HEALTH	AND HUMAN SERVICES		¥20	PRINTED: 0	1/17/2012
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	•		FORM AP	PROVED
AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION ING	(X3) DATE SURV	ΈΥ
		445494	B. WING		1	
NAME OF	PROVIDER OR SUPPLIER				01/11/2	012
LIFE CA	ARE CENTER OF RHE	The state of the s	,	TREET ADDRESS, CITY, STATE, ZIP CODE 7824 RHEA COUNTY HWY DAYTON, TN 37321	(x)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	III D RE C	(X5) DMPLETION DATE
F 164	Continued From pa	ge 1	F 164	what systematic changes will you	make to	
.	Based on medical and interview, the faresident's right to prelighteen residents residents resident #1 was additional February 24, 2011, and February 24, and February 25, and February 25, and February 26, and	mitted to the facility on with diagnoses including and the mentia, Anemia, Attack, and Chronic nia. The word the Minimum Data Set ber 8, 2011, revealed the dependent for activities of a was incontinent of bowel. The word the minimum Data Set ber 8, 2011, revealed the dependent for activities of a was incontinent of bowel. The word the resident lying on dy facing the outside window ervation revealed the gerineal care (washing of as) for bowel incontinence assistant (CNA) #1 and CNA wation revealed the privacy the resident was uncovered as being performed. The wheelchair facing the continence are washing performed.		ensure that the deficient practice of recur? a) All facility personnel were in serviced on privacy and dignity residents by the Staff Develoy Coordinator on 1/9/2012 and 1/26/2012. b) Unit manager and/or Assistant Director of Nursing will compweekly observation on privace dignity of residents for four wand weekly for two months. c) The DON will audit the unit manager/ADON weekly obserfor compliance starting on 1/2 to 2/17/2012 and weekly for two months. How the corrective action(s) will two months.	ity of priment it plete y and reeks it vation 27/2012 wo be practice urance ity rmance ity rmance ith rector	
1	resident and observin	g the perineal care.		en s	i	

Interview with the Director of Nursing (DON) on January 10, 2012, at 1:52 p.m., in the hallway

DEPAR	RTMENT OF HEALTH	AND HUMAN SERVICES			PRINTE	D: 01/17/201;	2
STATEMEN	ERS FOR MEDICARE	& MEDICAID SERVICES			OMBNO	M APPROVED 0. 0938-039)
AND PLAN	VT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTA. BUILDI	FIPLE CONSTRUCTION NG	(X3) DATE :	SURVEY	_
		445494	B. WING				
NAME OF	PROVIDER OR SUPPLIER	445494	15: 11110		01/	11/2012	
			ST	REET ADDRESS, CITY, STATE, ZIP CODE			7
LIFE CA	RE CENTER OF RHEA	COUNTY		7824 RHEA COUNTY HWY			1
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		DAYTON, TN 37321			
PRÉFIX TAG	(EMON DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOTO CROSS-REFERENCED TO THE APPRICIENCY)	HUDE	(X5) COMPLETION DATE	
F 164	Continue	-		Cont. FIGH			1
1 104	Tom pay	ge 2	F 164	human resource director, soci	ial	1.	ļ
	outside the Adminis	trator's Office, confirmed a	100	service director, rehab service	28	1	ı
W	residents buyacy co	ITIAIN was to be closed when		manager, dietary manager			l
F 332	personal care is per	formed.		admission/marketing coordinate	ator,		1
SS=D	RATES OF 5% OR	OF MEDICATION ERROR	F 332	Uusiness office manager wou	nd		1
		WORE		inuse, nousekeening/launders	director	İ	ı
	The facility must ens	sure that it is free of		activity coordinator, and healt information manager, for three	h		Į
	medication error rate	es of five percent or greater.		months.	3	İ	
		posterior groater,		b) The performance improvemen		1	
		ti ui		committee will review the reco	ile Te		
	This OFOLUDERATE			it is deemed necessary by the			
	by:	T is not met as evidenced		committee, additional education	n may		
		n modical		ne provided; the process			
	review of manufacture	on, medical record review, rer's specifications, facility		evaluated/revised and/or the au	dits		
22	poncy, and interview.	the facility failed to provent		reviewed, for three months or t	ıntil		
	in four errors within fo	s than five percent resulting		100% compliance is achieved.			
ĺ	Adam all allol (Sie Ul	eight percent	1	, t			
	(Licensed Densting N	ed errors occurred with one	İ	F332	()	2/24/2012)
}	one (New Side Hall)	lurse [LPN] #1) of five LPNs,		What corrective action will be	\		1
i	Cart #2) of three mod	of two halls, one (Medication	-	TOTAL UITS ATTROPED HATE	S. (0.50 p.)		
	2 p.m) of three shifts	lication carts, one (6 a.m., to s, and two (#10, #6) of	1	The state of the s			
	eleven residents obse	erved	-	Call Development nime		ł	
1				would dullinistration — - J!		į.	
	The findings included:	:		Bren will lood dilution of	1		
		1		medications and medication no crushed.	t to be	-	
11	Medication Error #1			or notice.	500 m 540 m 600 m		
	Theopiation t			All licensed personnel were in- serviced on insulin administration		Ì	
1 5	he Medication Cost #	ry 9, 2012, at 9:33 a.m., at		medications to be given with c	on,		
a	he Medication Cart #2	formin 500 max (diduoii of medications and		I	
t	ablet for Diabetes to F	formin 500 mg (milligram)	į	medication not to be crushed			
[]		resident#10.		1/9/2012 and 1/26/2012 hy staff			
· N	Medical record review	of the January 2012		development coordinator.		1	
r	recapitulation orders t	for Resident #10 revealed	ļ	• 55395	į	ļ	
ia	n order for " METEC	PMIN FOOM	1	3	1	1	

DEPAR	RTMENT OF HEALTH	I AND HUMAN SERVICES			DDINTE	D: 01/17/201;
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			FOR	M APPROVE
DIALEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MU	LTIPLE CONSTRUCTION	OMB NO	D. 0938-039
		DENTI IONTION NOWBER;	A, BUILD	DING	COMPI	LETED
		445494	B. WING		}	
NAME OF	PROVIDER OR SUPPLIER				01/	11/2012
	RE CENTER OF RHEA	COUNTY	S	TREET ADDRESS, CITY, STATE, ZIP CODE 7824 RHEA COUNTY HWY		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		DAYTON, TN 37321		
PRÉFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OHIDE	(X5) COMPLETION DATE
F 332	Continued From particle TABLETTAKE 1 1 EVERY MORNING.	AB (tablet) BV MOUTH	F 33	2 Identify residents that have the to be affected by the alleged determined practice.	potential ficient	
	Review of the manu Metformin in the Ge Sixteenth Edition pa "Administration"	facturer's specifications for riatric Dosage Handbook ge 1103, under		a) All residents that receive in medications to be given wit medications to be diluted or medications that are not to be crushed could be affected.	th food, r be	
198	Review of the facility Recommendations f revealed Metformin v Food".	's policy, "Food/Water or Certain Drugs", page 9-18 was to be administered "With		b) 100% audit of all residents receive insulin, medications given with food, medication diluted or medications that a be crushed could be affected completed by Assistant Dire Nursing on 1/27/2012. No complete to the county of	to be as to be are not to I was ector of	
	resident rooms 23 ar Hallway confirmed R food at the time the Method breakfast tray for January 9, 2012, beth a.m.; and one medicathe Metformin tablet of food and approximate minutes after breakfa	E		what measures will be put into pl what systematic changes will you ensure that the deficient practice of recur? a) All licensed personnel were in serviced on insulin administra medications to be given with dilution of medications and medication not to be crushed (1/9/2012 and 1/26/2012 by sta	ace or make to loes not n- ation, food,	
	on January 10, 2012, (Minimum Data Set) of trays were served to the first trays and lunch the sidents beginning at 2012; and no other model ween breakfast and the first trays.	actor of Nutritional Services at 10:20 a.m., in the MDS office confirmed breakfast the residents beginning at rays were served to the 11:30 a.m., on January 9, eal trays were served d lunch.		development coordinator. b) A list of "do not crush" medications to be diluted in w juice, insulin perimeters, and medications to be given with f was placed on each medication administration record binder. c) Medication pass procedure will observed weekly for 4 weeks to mostly for two months.	food n U be	
	Medication Error #2 Observation on Janua	ry 9, 2012, at 9:44 a.m., at		monthly for two months by the Director of Nursing or Staff Development Coordinator or pharmacy representative for	,	

pharmacy representative for

compliance.

DEPA CENT	RTMENT OF HEALTH	AND HUMAN SERVICES			PRINTE	D: 01/17/2012
STATEME	INT OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N	MULTIPLE CONSTRUCTION	OMB NO	M APPROVED 0. 0938-0391 SURVEY
	8	445494	A. BUI	ILDING	COMP	LETED
NAME OF	PROVIDER OR SUPPLIER				01/	11/2012
	ARE CENTER OF RHEA			STREET ADDRESS, CITY, ST, 7824 RHEA COUNTY HW DAYTON, TN 37321	ATE, ZIP CODE	
PREFIX TAG	LEAGO DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFI TAG	CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
	Medical record reviee Recapitulation orders for "Humulin VIAL" per sliding so DAILY" Review of the manufing Humulin R insulin review with LPN #110:09 a.m., at Medical resident rooms 23 and Hallway confirmed the #6 was served on Jara.m., and 8:00 a.m., a occurred when the Huadministered "thirty mapproximately one hor breakfast was served. Interview with the Dire on January 10, 2012, a office confirmed breakfast beginning trays were served to the residents beginning trays were served to the residents or the residents beginning trays were served to the residents beginning trays were served to the residents beginning trays were served to the residents beginning trays were served to the residents beginning trays were served to the residents beginning trays were served to the residents beginning trays were served to the residents beginning trays were served to the residents beginning trays were served to the residents beginning trays were served to the residents beginning trays were served.	#2, revealed LPN #1 of Humulin R Injectable ml (milliliter) for Diabetes der the skin) to the upper arm of Resident #6. w of the January 2012, s for Resident #6 revealed at R 100UNIT/1ML (milliliter) cale insulin "FOUR TIMES acturer's specification for realed, "The injection of culd be followed by a meal 30 minutes of on January 9, 2012, at ation Cart #2 outside d 24 in the New Side Front acturery 9, 2012, between 7:30 and one medication error inutes before a meal" and ar and forty minutes after ctor of Nutritional Services at 10:20 a.m., in the MDS fast trays were served to g at 7:30 a.m., and lunch are residents beginning at		d) The DON or N Administrator Medication passobservations st 2/17/2012 and months. How the corrective monitored to ensure will not recur and w program will be put e) The Director of Home Administrator, in director of mursi of nursing, staff coordinator, pha human resource service director, manager, dietary admission/marke business office in nurse, housekeep activity coordina information man months. The performance committee will re it is deemed nece committee, addit	Jursing Home will review the ss procedure arting on 1/27/2012 to weekly for two action(s) will be the deficient practice that quality assurance in place? Nursing or Nursing trator will report the cation pass procedure rformance committee, which arsing home medical director, ing, assistant director development armacy consultant, director, social rehab services manager, eting coordinator, manager, eting coordinator, manager, eting coordinator, manager, eting cordinator, manager, tor, and health ager, for three	OA)E
11	11.30 a.m., on Januar	9, 2012; and no other between breakfast and		be provided; the evaluated/revised reviewed, for thre 100% compliance	and/or the audits	

DEPAR	RTMENT OF HEALTH	HAND HUMAN SERVICES				PRINTE	D: 01/17/2012
_CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTI	TPLE CONSTRUCTION NG	(X3) DATE	
	1	445494	B. WI	NG_		1	
NAME OF	PROVIDER OR SUPPLIER			STE	REET ADDRESS, CITY, STATE, ZIP CODE		11/2012
LIFE CA	ARE CENTER OF RHE	A COUNTY		7	7824 RHEA COUNTY HWY DAYTON, TN 37321		
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F 332	Continued From pa Medication Error #3	ge 5	F:	332			
E.	administered 15 ml	uary 9, 2012, at 9:44 a.m., at #2, revealed LPN #1 s (20 meq [milliequivalents]) of Solution for potassium with to Resident #6.	•			s.	
	recapitulation orde	ew of the January 2012, rs for Resident #6 revealed an otassium Chloride) 20 meq po ce daily)"	02				
÷	December 22, 2011 administration instru	Solution dispensed on to Resident #6 revealed actions to "Take with plenty 4-8oz (ounces) water/juice.			e e	# # # # # # # # # # # # # # # # # # #	
92	Review of the manu Chloride Solution rev DILUTED"	facturer's label for Potassium /ealed, "MUST BE	20		· · · · · · · · · · · · · · · · · · ·		
	Handbook Sixteenth 1438, under "Admi	facturer's specification for in the Geriatric Dosage Edition pages 1437 and nistration" revealed, "Oral be taken with meals"				8 at	
	resident rooms 23 and Hallway confirmed Rother time the Potassius administered and the #6 was served on Jan	1 on January 9, 2012, at attention Cart #2 outside and 24 in the New Side Front esident #6 was not eating at m Chloride Solution was breakfast tray for Resident nuary 9, 2012, between 7:30 further interview with LPN #1	el V				

DEPAR CENTE	TMENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES					100	FORM	0: 01/17/2012 MAPPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI		CONSTRUCTION	ON	(X3)). 0938-0391 SURVEY ETED
	270	445494	B. WIN	G				04/	44/2042
NAME OF I	PROVIDER OR SUPPLIER		1	STREE	TADDRESS CI	TY, STATE, ZIP (ODE	01/	11/2012
	RE CENTER OF RHEA	an mark an areas at see		7824	TON, TN 37	TY HWY	ODE	ä	
(X4) ID PREFIX TAG	EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	(EACH CO	ER'S PLAN OF C RRECTIVE ACTION ERENGED TO THE DEFICIENCY	ON SHOULD E E APPROPRI	BÉ ATE	COMPLETION DATE
F 332	the Potassium Chlo administration; was	cation error occurred when ride was not diluted before administered without food one hour and forty minutes	F3	32					
	on January 10, 2012 office confirmed bre the residents beginn trays were served to 11:30 a.m., on Janu	rector of Nutritional Services 2, at 10:20 a.m., in the MDS akfast trays were served to ing at 7:30 a.m., and lunch the residents beginning at ary 9, 2012; and no other yed between breakfast and			,	21	** ₁₈		
1	Medication Error #4	*		1		,			
	one Suboxone (com Buprenorphine and 2 (under the tongue) fill dose to Resident #6.	lary 9, 2012, at 9:44 a.m., at revealed LPN #1 crushed bination medication of 8 mg 2 mg Naloxone) sublingual im for pain and handed the Resident #6 swallowed the placing it under the tongue.				n *			6
ļ	order for "SUBOXO	TAKE 1 TAB BY MOUTH	.,,			5		٠	
	"Method of Adminis sublingual revealed, " be kept under the ton	SUBOXONE subilingual hewed, swallowed or				36)	5 3		

DEPAR	RTMENT OF HEALTH	HAND HUMAN SERVICES			PRINTED: 01/17/2013	2
CENTE	ERS FOR MEDICARE	& MEDICAID SERVICES		*	FORM APPROVE	D
AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE	LTIPLE CONSTRUCTION DING	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	1
		445494	B. WING)	
NAME OF	PROVIDER OR SUPPLIER				01/11/2012	
LIFE CA	ARE CENTER OF RHE	A COUNTY	S	TREET ADDRESS, CITY, STATE, ZIP CODE 7824 RHEA COUNTY HWY DAYTON, TN 37321		
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES	ID			
TAG	(CAUT DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	UII D. D.C.	
F 332	Continued From pa	ge 7		Tue :		1
	**************************************	21	F 33			1
	Interview with LPN	#1 on January 9, 2012, at		What corrective action will be ta correct this alleged deficient prac	tken to 2/24/2012	1
	resident rooms 23 a	ledication Cart #2 outside and 24 in the New Side Front		a) Resident #11 pharmacy recommendation was addressed		1
	I ICHWAY COMMINDED A	medication offer continue !		immediately with the attending p	hysician	1
	and administered by	Suboxone film was crushed the incorrect route of		on 1/12/2012.	nysician	
F 400	: PMGIIOWIIIO.		1.	Identify residents that have the p	otential	ĺ
F 428	483.60(c) DRUG RE	GIMEN REVIEW, REPORT	F 428	to be affected by the alleged defice	cient	
33-0	IRREGULAR, ACT	ON .	"-	practice.		l
	The drug regimen of	each resident must be		a) Residents in the facility that	receive	
i	Leavened at 16981 OUG	ce a month by a licensed		pharmacy services from the pharmacy have the potential	tacility to be	
İ	pharmacist.	, * Simon		affected.	10 06	
	The pharmacist mus	t report any irregularities to		b) All other pharmacy		
į	WING CITICALLIA DUNCKE	an and the diseastt		recommendations for the mo December were reviewed by	nth of	
j	nursing, and these re	ports must be acted upon.		director of nursing and found	ine	-
		2	17	compliance. No other residen	nts were	
į	5/			affected.		
-				What measures will be put into pl	300.00	
ļ.	This REOLUBEMENT	·	,	what systematic changes will you	make to	
į,	by:	is not met as evidenced		ensure that the deficient practice of	loes not	
	Based on medical rea	cord review and interview,	[recur? a) All monthly pharmacy		
10.5	are recility islied to bu	SIITE the physician	ĺ	recommendations will be take	en to	
1.	cobolinga fittleth to b	narmacy recommendations		physician's office by Health		
fr	for one resident (#11) eviewed.	of eighteen residents	-	Information Manager for their	review	
	rt - A	i	İ	starting 1/27/2012. A copy of signed recommendation will be	the	
1	The findings included:	į		to the Director of Nursing to e	nsure	
F	Resident #11 was adn	nitted to the facility on		timely response. b) Director of Nursing will audit		
1	*Overriber 20, 2011. M	/IID diagnoses including	-	monthly recommendations for	timely	
į L	Dementia, Anxiety, and	d Psychosis.	i	physician review beginning		
I	Medical record review	of a Pharmacy		1/28/2012 and ongoing.		

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			FORM): 01/17/2012 A APPROVED
JOINTEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE (COMPL). 0938-0391 SURVEY
		445494	B. WING)	
	PROVIDER OR SUPPLIER		sı	TREET ADDRESS, CITY, STATE, ZIP COD	01/	11/2012
	RE CENTER OF RHEA	4		7824 RHEA COUNTY HWY DAYTON, TN 37321	E .	
(X4) ID PREFIX TAG	1 CANON DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 431 SS=D	increasing Namend. 10 mg (milligrams) maintenance dose." Continued medical rephysician had not represent the physician had not represent the physician had not represent the physician of the Phates and the physician of the Phates and the physician of the Phates and the physician of the Phates and the physician of the Phates and the physician of the Phates and the physician of the Phates and the physician of the Phates and the physician of the Phates and the physician of the Phates and the physician of the Phates and the physician of the Phates and the physician of the Phates and the physician of the Phates and the physician of the Phates and the physician of the Phates and the physician of the Phates and the Pha	dated December 13, 2011, mendation: Please consider a (medication for dementia) to to twice daily as ecord review revealed the exponded to the rector of Nursing on January .m., in the Social Services facility delayed notifying the rmacy recommendation. RUG RECORDS, IGS & BIOLOGICALS bloy or obtain the services of st who establishes a system and disposition of all entitled and periodically and that an account of all entitled and periodically used in the facility must be with currently accepted and cautionary expiration date when the rugs and biologicals in under proper temperature only authorized personnel to	F 428		nt practice assurance Nursing eport the the f the medical assistant carmacy director, o services mator, und care director, lth ee ent sults. If ion may mudits until	

PRINTED: 01/17/2012

DEPA CENT	RTMENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES	(X		PRINTED: 01/17/2012 FORM APPROVED
SIMIEME	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION'	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
		445494	B. WING		}
NAME OF	PROVIDER OR SUPPLIER				01/11/2012
LIFE ¢	ARE CENTER OF RHEA	COUNTY	S	TREET ADDRESS, CITY, STATE, ZIP CODE 7824 RHEA COUNTY HWY	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	THO BE COMME
	controlled drugs listed controlled drugs listed Comprehensive Dru Control Act of 1976 abuse, except when package drug distrib quantity stored is min be readily detected. This REQUIREMENT by: Based on observation review of Tennessee Edition, and interview the contents of emergresidents were securially Emergency Box) observed. The findings included Observation of the Bit January 9, 2012, at 12 Medication Room with (LPN) #2 revealed the Further review of the IV Emergency Box rev Solutions, including Downserved Water 1000 ml (millilition) was for residents.	compartments for storage of ed in Schedule II of the graph Abuse Prevention and and other drugs subject to the facility uses single unit ution systems in which the nimal and a missing dose can be in the facility facility policy, Pharmacy Laws 2011 to the facility failed to assure gency medications for ed in one (Blue Intravenous of nine emergency boxes) in the New Side of Licensed Practical Nurse box was not locked. It is to for contents of the Blue realed 23 Intravenous extrose 5% (per cent) with ear) bag and Normal Saline re available for emergency	F 43	E42:1	erviced dinator a proper ncy cential ent ecked re ces ce or nake to nes not rviced inator oroper cy all sis
	poyLocednie lev	olicy, "Emergency Drug realed "1. The head necks the expiration date		months.	

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES			2	PRINTED FORM): 01/17/2012 APPROVED
STATEMEN	IT OF DEFICIENCIES	& MEDICAID SERVICES				OMB NO	0. 0938-0391
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL		CONSTRUCTION	(X3) DATE S	
		445494	B. WIN	G		1	
NAME OF	PROVIDER OR SUPPLIER	170,54				01/	11/2012
		*	1		ADDRESS, CITY, STATE, ZIP CODE		
LIFE CA	RE CENTER OF RHEA	COUNTY	- 1		RHEA COUNTY HWY TON, TN 37321		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES			The second secon		
PRÉFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	K	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 431	Continued From pa	10		J	How the corrective action(s) will	ll be	
	and seal on the box		F 4		nonitored to ensure the deficien		
	and sear on the pox	On each shift"			will not recur and what quality a	ssurance	
	Review of the Tenn	essee Pharmacy Laws 2011			program will be put in place?		
	Edition Rule 1140-4	09 Emergency and Home			 The Director of Nursing or Home Administrator will re 	Nursing	
	Care Kits page 210	documented " (3) The	20		results monthly pharmacy	port the	
	emergency kit shall	be provided sealed or			recommendation audits to the	he.	
	electronically secure	ed by authorized personnel in			performance improvement		
	accordance with est	tablished policies"			committee, which consist of	f the	
	Interview with LPN 4	\$2 on January 9, 2012, at 1:20			nursing home administrator	, medical	!
	p.m., in the New Sid	le Medication Room,	:		director, director of nursing	, assistant	!
	confirmed the Blue	Intravenous Emergency Roy			director of nursing, staff	•	i
	was unlocked and th	ne contents of the emergency			development coordinator, p consultant, human resource	narmacy	
-	box were not secure	d per facility policy			social service director, rehal	director,	1 1
F 441	483.65 INFECTION	CONTROL, PREVENT	F 44	11	manager, dietary manager,) 901 A1CC2	
SS=D	SPREAD, LINENS	1	**		admission/marketing coordi	nator.	
	The facility must not	oblish and a second			business office manager, wo	ound care	
	Infection Control Pro	ablish and maintain an ogram designed to provide a	. 10		nurse, housekeeping/laundr	y director,	
	sale, samilary and co	omtottable environmont and			activity coordinator, and hea	alth	
40	to neip prevent the d	evelopment and transmission			information manager, for the months.	ree	i 1
	of disease and infec	tion.		b		ant	
	(+) (-(-)			"	committee will review the re	esults If	
	(a) Infection Control	Program			it is deemed necessary by th		
	Program under which	ablish an Infection Control			committee, additional educa	tion may	
	(1) Investigates con	trois, and prevents infections			be provided; the process		
	in the facility;	irois, and prevents infections		;	evaluated/revised and/or the	audits	
	(2) Decides what pro	cedures, such as isolation,			reviewed, for three months of		
	should be applied to	an individual resident, and			100% compliance is achieve	a.	- 1
	(3) Maintains à recor	d of incidents and corrective					
	actions related to infe	ections.			a		
	(b) Preventing Sprea	d of Infaction			10		
	(1) When the Infection	n Control Program					**
į	determines that a res	sident needs isolation to		į	* :		
i	prevent the spread of	f infection, the facility must		i			
	isolate the resident.	, and make		-	50		

CENTE	RS FOR MEDICAR	E & MEDICAID SERVICES			OMPAIC	APPROVED
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		445494	B. WING_			
NAME OF	PROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP C	01/	11/2012
LIFE CA	ARE CENTER OF RHE	EA COUNTY	7	1824 RHEA COUNTY HWY DAYTON, TN 37321	OUE	
(X4) ID PREFIX TAG	REACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 441	from direct contact direct contact will t (3) The facility must hands after each d hand washing is in professional practic (c) Linens Personnel must ha	st prohibit employees with a ease or infected skin lesions with residents or their food, if ransmit the disease. St require staff to wash their irect resident contact for which dicated by accepted.	F 441	F441 What corrective action will correct this alleged deficien a) RN #1 was educated by Nursing and Staff Deve Coordinator on infection relation to proper hand usage of gloves on 1/9//1/20/2012. b) All personnel were insinfection control in relation washing and usage staff development coord 1/9/2012 and 1/26/2012	t practice? Director of clopment n control in washing and 2012 and erviced on tion to proper of gloves by linator on	2/24/2012
	Based on observatinterview, the facility technique and wash during a dressing cleighteen residents of the findings included the find	8		Identify residents that have to be affected by the alleged practice. a) All facility residents have potential to be affected. b) Staff Development Coorcompleted a 100% obser 1/26/2012 on infection or residents. No other residents.	deficient ve the rdinator rvation on control of all	

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CENTEDS FOR MEDICADE & MEDICADE OF THE TOTAL					PRINTED: 01/17/2012 FORM APPROVED OMB NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445494		(X2) MULTIPLE CONSTRUCTION A BUILDING B. WING		(X3) DATE SURVEY COMPLETED		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	SHOULD BE COMPLETION	
	Review of the facility's policy Wound Care Procedure for Major Wounds revealed "'Clean technique' is usedPut on clean glovesClean the wound according to the order. Clean from the center outwardPlace soiled gauze used for		F 441	ensure that the deficient practice d	make to	
				a) All personnel were in-service infection control in relation to hand washing and usage of gl Staff Development Coordinat	proper loves by	
	Interview on Janual RN #1, in the hallwathe wounds on the Stage II pressure ut 1.2 cm (centimeters interview revealed with a separate gauthands were to be wound prior to application.	y 9, 2012, at 2:55 p.m., with ay, revealed RN #1 described right and left buttocks as leers measuring approximately by 1.4 cm. Continued each wound was to be cleaned lize pad, and confirmed the ashed after cleansing a lying a clean dressing.		b) Director of Nursing will cond visual audits starting 1/19/2012 2/16/2012 and then monthly f months on proper infection co process during wound care with wound care nurse. c) Nursing Home Administrator audit the infection control proweekly reviews for compliant four weeks and monthly for the months.	luct 12 to for two ontrol ith will ocess ce for	
	Observation on January 9, 2012, at 2:00 p.m., revealed RN #1 providing wound care to resident #6. Observation revealed after completing wound care to resident #6, RN #1 removed the gloves and washed the hands. Continued observation revealed the following: RN #1 reapplied gloves and placed soiled linens into a plastic bag and picked up a bag with soiled dressings; placed the soiled linens into a laundry cart, and placed the bag with the soiled dressings into a biohazard storage box in the soiled utility room; removed the gloves and without washing the hands returned to resident #6's room and removed scissors from a drape on the resident's table, unlocked the dressing cart, and obtained a bleach wipe to clean the scissors. Review of the facility's policy Standard		· · · · · · · · · · · · · · · · · · ·	How the corrective action(s) will monitored to ensure the deficient will not recur and what quality ass program will be put in place? a) The Director of Nursing or Nursing or Nursing or Nursing or Nursing or Nursing or Nursing infection control audit performance improvement committee, which consist of the nursing home administrator, and director, director of nursing, and director of nursing, staff development coordinator, phaeconsultant, human resource director, rehabits manager, dietary manager,	practice surance fursing ort the s to the the medical assistant armacy irector, services	
	Precautions revealed	d "The purpose is to		admission/marketing coording business office manager, wou		

PRINTED: 01/17/2012 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A, BUILDING B. WING 445494 01/11/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7824 RHEA COUNTY HWY LIFE CARE CENTER OF RHEA COUNTY DAYTON, TN 37321 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FUILL (EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) wont F441 Continued From page 13 nurse, housekeeping/laundry director, F 441 activity coordinator, and health Standard precautions apply to all residents and in information manager, for three all situations...The required elements of standard months. precautions include: 1) adequate hand hygiene at The performance improvement all times...Follow hand hygiene recommendations committee will review the results. If immediately or as soon as feasible after removal it is deemed necessary by the of gloves..." committee, additional education may be provided; the process Interview on January 9, 2012, at 2:25 p.m., with evaluated/revised and/or the audits RN #1, in the hallway, confirmed the hands were reviewed, for three months or until not washed after placing the soiled linens into the 100% compliance is achieved laundry cart and the soiled dressing into the biohazard storage box, and removing the gloves, prior to reentering the resident's room and unlocking the dressing cart to clean the soiled scissors.